End of Life Issues Committee
Minutes

Thursday, June 27, 2002
DHMH

Jean Tucker Mann: University of Maryland's Palliative/Supportive Care Program

1. Review of practices in US, Australia and Netherlands
2. Typical Models:
    a. Curative/Restorative Care then transition to Palliative/Supportive Care
    b. Curative/Restorative Care concurrent with Palliative/Supportive Care
3. Developed Screening Criteria (suffering, concern about options, ventilator for 7+ dyas, condition trending down, survival unlikely)
4. Developed a Care Model (pilot to current use)
    a. Screen
    b. Refer to PCT
    c. Case Presentation
    d. PCT doc consults with attending/ PCP ->> yes or no
    e. PCT care plan initiated
    f. Continuous care by PCT (MD, RN, SW & Chaplain)
5. Dedicated team – Hospital-Wide program – Funded with operational dollars
6. Interface with Primary Care Team is treated as a partnership with care team as primary and PCT as secondary. Conflicts may be handles via ethics committee
7. MD consults with other MD's to ease transition and forge a path for PCT
8. RN conducts initial assessment; consults with care team staff; provides pain and symptom management, etc.
9. Research component being developed for grant proposals.
10. Pediatric component grant has been submitted.
11. Satisfaction Surveys now being conducted with care team, PCT, patient and families.
12. Advanced Directive conflicts are managed by the Medical Center Attorney, with an ethics committee consult as needed.
13. Patient and family permission is always sought before proceeding.
14. Challenges:
    - Late referrals
    - Image as end of life team
    - Acceptance by physicians overall
    - 24-hour availability

- System-wide education
- Funding

15. Optimum caseload was 5/week during pilot. Now 8-10. As many as 8 referrals may come in each day.

Irene Williams: Managed Care And Reimbursement Variances

1. Short length of stay is a critical issue
2. Consumers need to be informed about barriers in coverage in health plans. (i.e. maternity benefits for non-child bearing women that may parlez into hospice benefits)
3. 79 In-patient hospice beds in MD -- 24 are at Gilcrest
4. $110/ day is the reimbursement rate for routine hospice care
5. $490/ day reimbursement rate under Medicare
6. Reimbursement variances are critical

- Carroll Hospice will soon be breaking ground on an 8-bed facility
- Linda will check Bureau of Health Statistics for data group requested.
- Bowie will follow up with Bill Vaughn pertaining to Evercare data.

Next meeting – will focus on Pediatric issues. Bowie will survey for dates.